Chapter XII: Enter and Maintain Patient Information

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Patient Information Data Entry Overview

The **Patient Info** chart section contains a list of **Data Entry** options. You can click on an option to add new or, in some cases, maintain specific patient information.

The data entry options are primarily used to add new patient information. To edit existing information, you can select data in the **Summary View** and click **Details** to display the corresponding **Details** dialog box. You can use the **Details** dialog boxes to edit, discontinue, and delete information. Some information can only be modified via the Admission system and then interfaced into CRIS. Only the items that can be directly entered into CRIS will be addressed in this section.

Maintain Allergy Information

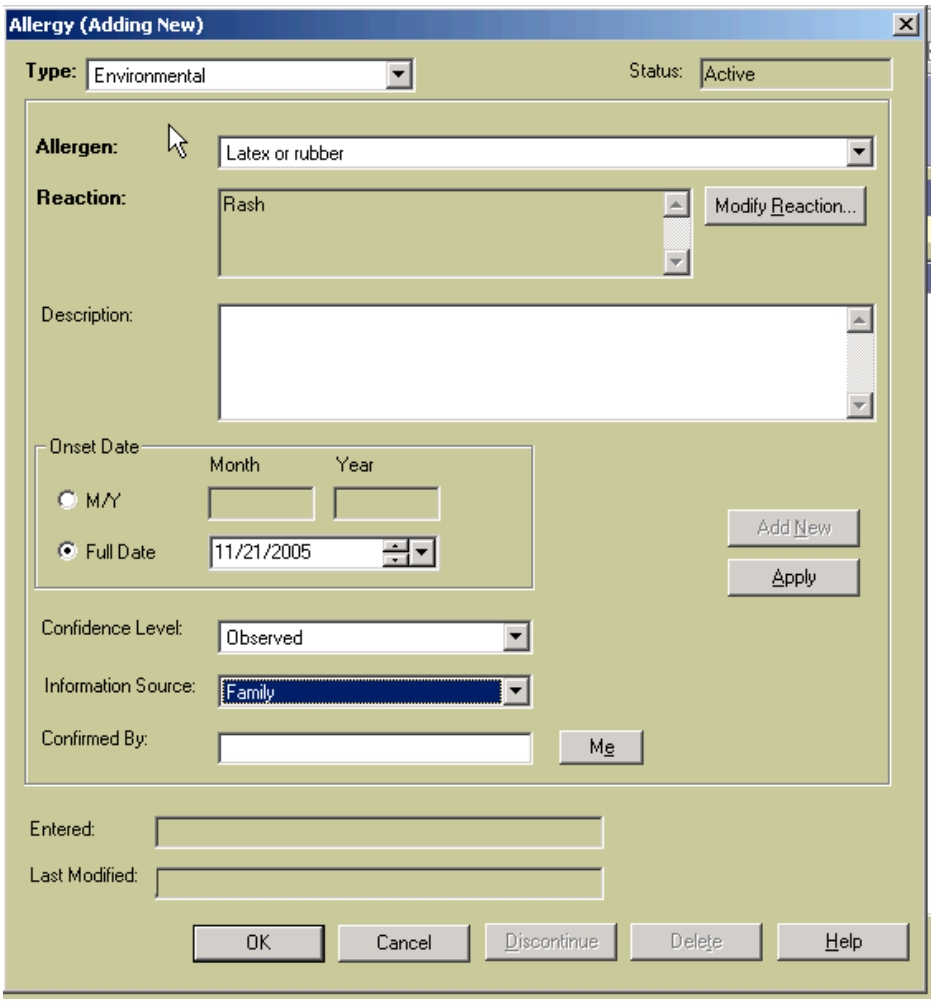
You can add patient allergies by clicking the **Allergy** data entry option in the **Patient Info** chart section. For example, if you've been informed that a patient has a penicillin allergy, you would first check to see if the allergy has been entered by looking at the **Allergies/Comments - Summary View**.

How to Add an Allergy

1. In the **Patient Info** chart section **Data Entry** list, select **Allergy**. The **Allergy Type** dialog box opens. If the patient has existing allergies and a new allergy is being added proceed to step 3.
2. Select **New Allergy** and click **OK**.
3. The **Allergy (Adding New)** dialog box opens.
4. Select a **Type** from the drop-down list.
5. Select an **Allergen** from the drop-down list.
6. Click the **Add Reaction** button. The **Reaction Details** dialog box opens.
7. If desired, select the **Select all reactions that apply** button. The reactions list is activated.
8. Select the check boxes for the desired reactions, and click **OK**.
9. If desired, enter a **Description** of the allergy.
10. Enter an **Onset Date** by clicking on the **Full Date** field drop down arrow and selecting a date on the calendar, or use the **M/Y** field to enter a month and year only, if that is all that is known.
11. If desired, select a **Confidence Level** from the drop-down list.
12. If desired, select an **Information Source** from the drop-down list.
13. If desired, enter the name of the person who confirmed the allergy in the **Confirmed By** field.
14. Click **OK**.

How to Edit an Allergy

1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Double-click an allergy, or select an allergy and click **Details**. The **Allergy Details** dialog box opens.
3. Make the desired edits. Note that you cannot edit the **Type** or **Allergen**.
4. Click **OK**.



Screen 12.1: Allergy Details Dialog Box

How to Discontinue an Allergy

1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Double-click an allergy, or select an allergy and click **Details**. The **Allergy Details** dialog box opens.
3. Click **Discontinue**.
4. Click **OK**. The status of the allergy changes to **Inactive**.

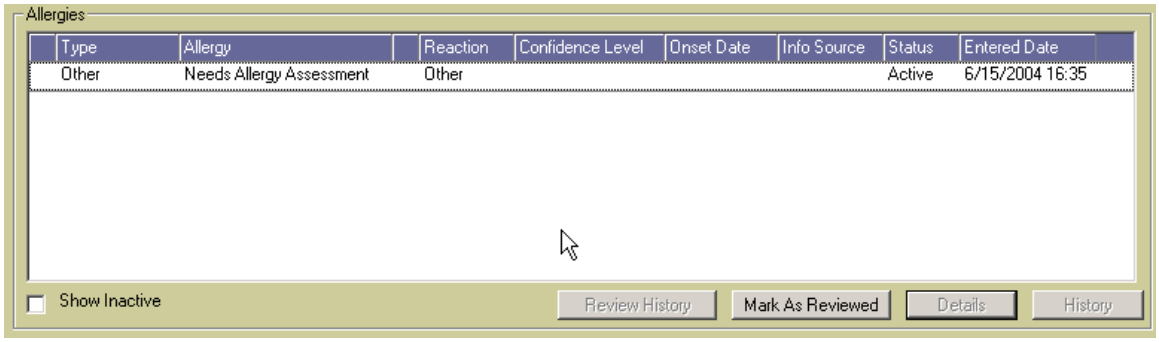
How to Delete an Allergy

1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Double-click an allergy, or select an allergy and click **Details**. The **Allergy Details** dialog box opens.
3. Click **Delete**. A confirmation message displays.
4. Click **OK**.

Note: *You can also view, add, and edit allergies from the Clinical Summary Tab.*

Needs Allergy Assessment

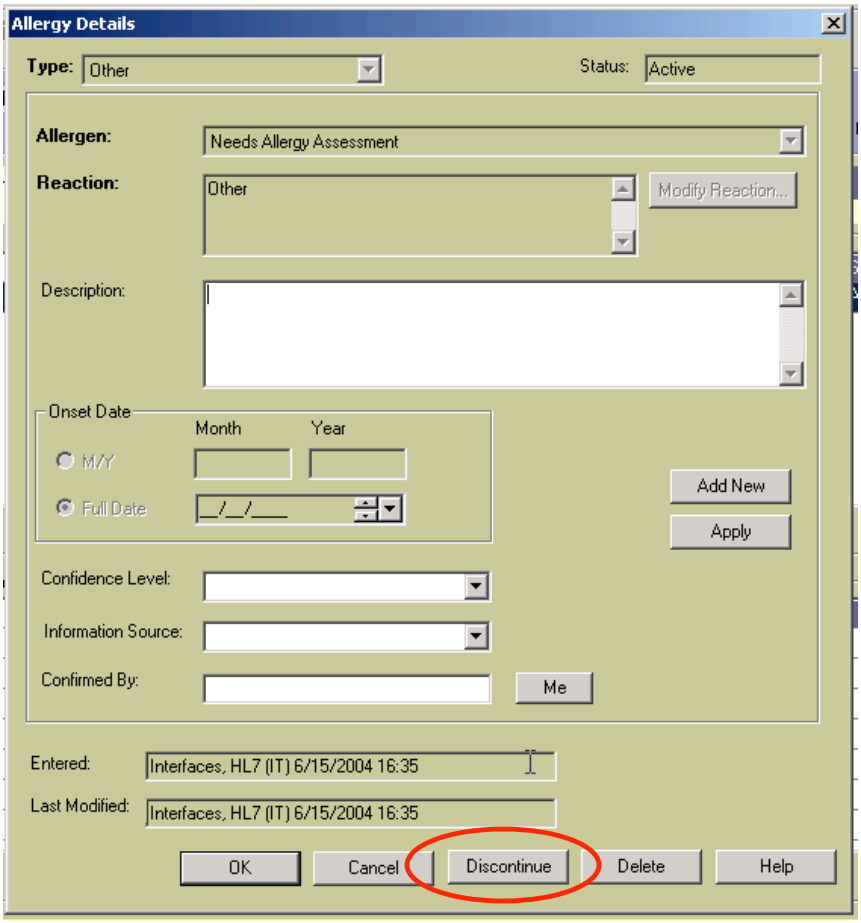
All patients with a first time NIH visit will have an allergy called **Needs Allergy Assessment**. The Needs Allergy Assessment allergy should be discontinued and actual patient allergies added.



Screen 12.2: Needs Allergy Assessment window

How to Discontinue the Needs Allergy Assessment

1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Double-click the Needs Allergy Assessment allergy and click **Details**. The **Allergy Details** dialog box opens.

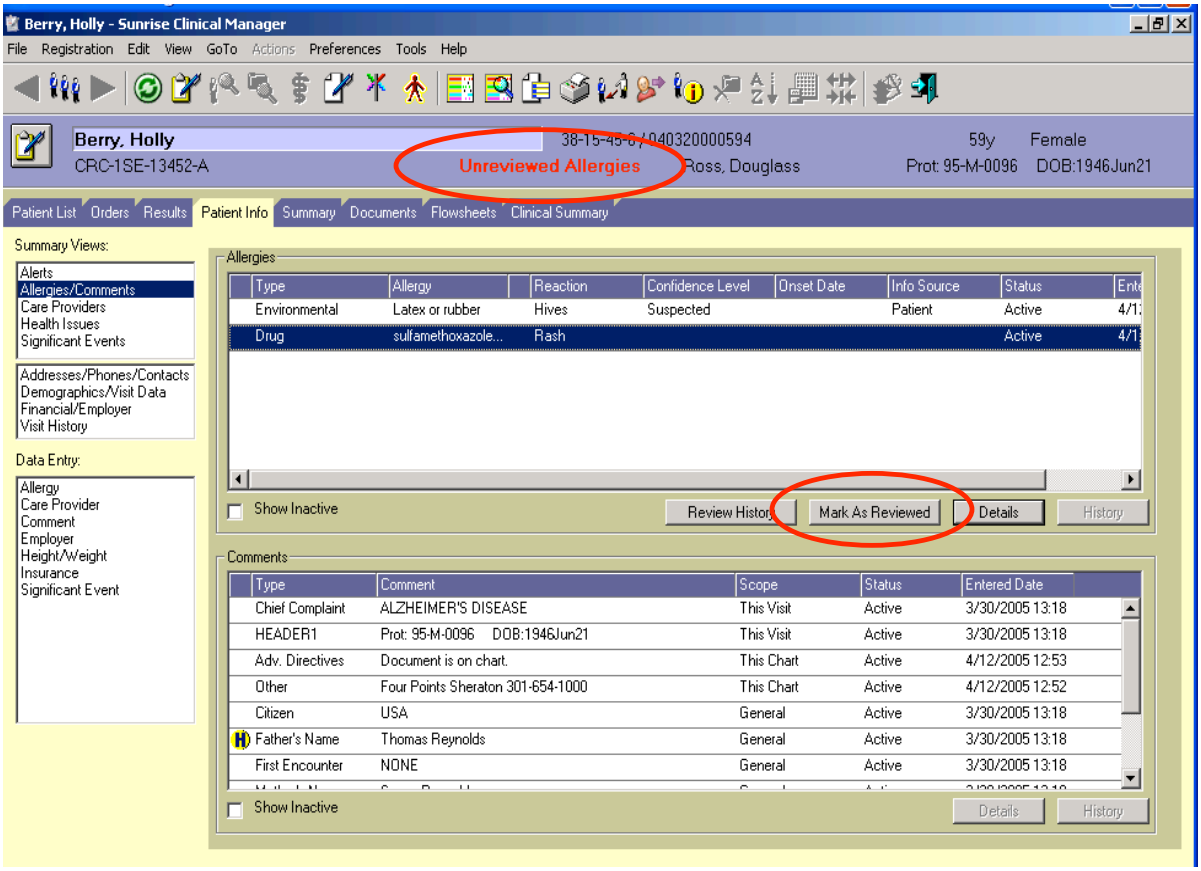


Screen 12.3: Allergies Detail window

3. Click **Discontinue**.
4. Click **OK**. The status changes to **Inactive**.
5. Add patient allergies as needed.

Mark Allergies as Reviewed

Once allergies have been discussed with the patient, they can be marked as reviewed.



Screen12:4 Unreviewed Allergies

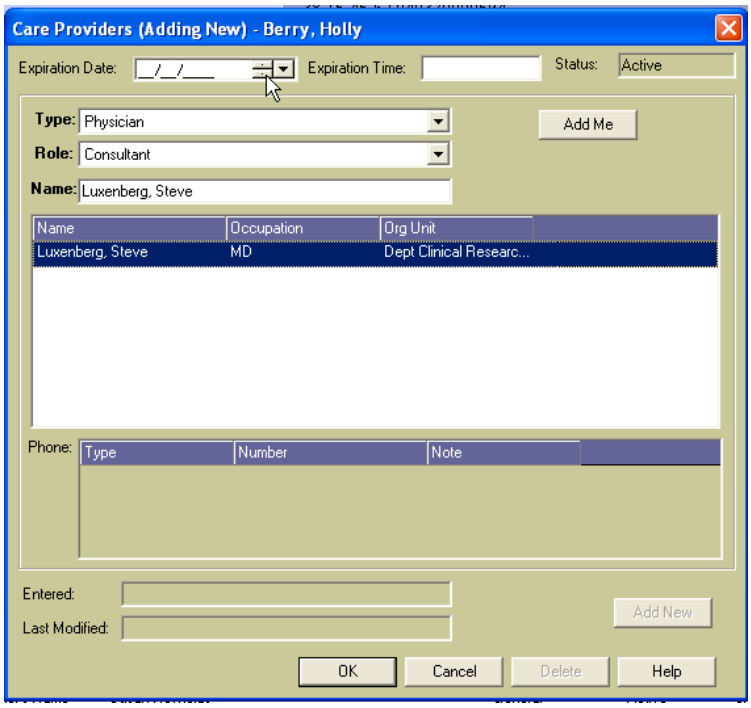
To mark all new allergies as reviewed:

1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Click **Mark as Reviewed**.

Once an allergy is reviewed, the Unreviewed Allergies in the patient header changes disappears.

Maintain Care Provider Information

You can add care provider information by clicking the **Care Provider** data entry option in the **Patient Info** chart section. You can add new care providers or add yourself as a care provider.



Screen 12:5 Add a Care Provider

How to Add a New Care Provider (Single Patient)

1. In the **Patient Info** chart section **Data Entry** list, select **Care Provider**.
2. The **Care Providers (Adding New)** dialog box opens.
3. Select a care provider **Type** from the drop-down list.
4. Select a care provider **Role** from the drop-down list.
5. Enter the care provider **Name**. As you enter each letter of the name, a list of matching names displays in a list below the **Name** field. If the name you want is in the list, you don't have to finish typing it. Select the name from the list. The care provider's phone numbers display.
6. Click **OK**.

How to Add Yourself as an Active Care Providers

1. In the **Patient Info** chart section **Data Entry** list, select **Care Provider**. The **Care Providers (Adding New)** dialog box opens.
2. Click **Add Me**. Your name display.
3. Click **OK**.

How to Discontinue a Care Provider Name

1. In the **Patient Info** chart section **Summary Views** list, select **Care Providers**.
2. Double-click on a care provider name, or select a care provider name and click **Details**. The **Care Provider Details** dialog box opens.
3. Enter an **Expiration Date**.
4. Click **OK**. The care provider status changes to **Inactive**.

How to Delete a Care Provider Name

1. In the **Patient Info** chart section **Summary Views** list, select **Care Providers**.
2. Double-click on a care provider name, or select a care provider name and click **Details**. The **Care Provider Details** dialog box opens.
3. Click **Delete**. A confirmation message displays.
4. Click **OK**.

Maintain Comment Information

Some comments will be interfaced into CRIS from Admissions, which appear in all capital letters. You can add other comments concerning the patient as needed. There are eight data entry types available to you:

- Advance Directives
- Deceased
- Interpreter
- Other
- Prosthesis
- Protocol Appts
- Special Needs
- VAD Line Hx

You can add comments by clicking the **Comment** data entry option in the **Patient Info** chart section.

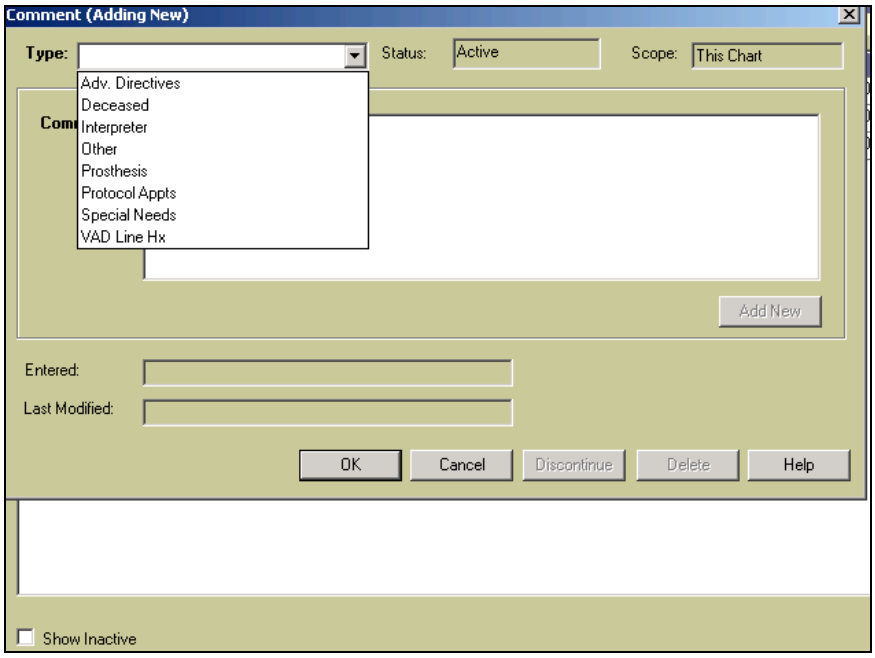
Comment Type Table

Comment Type	Comment Field	Scope	Multiple Entries	Entered By
Adv. Directives	Enter the of type of Advance Directive	This chart	Yes	Nursing staff following documentation
Chief Complaint	Admitting Diagnosis	General		Interfaced
Citizen	Citizenship	General		Interfaced
Father's Name	Patients fathers name	General		Interfaced
First Encounter	Date of first encounter	General		Interfaced
Header 1	Displays in header, top portion of screen. To be used for Protocol Number ONLY at this time. (Need to limit rights)	This chart		Interfaced
Header 2	Displays in header only if selected. No designated use at this time.	This chart		
Interpreter	Enter primary language, interpreter contact phone number, appointments, arrangements	This chart		Entry by Nursing, Anesthesia, Social Work
Mother's Name	Patients mothers name	General		Interfaced
Occupation	Normal occupation	General		Interfaced
Other	Any other general comments or communications not covered under other categories	This chart	Yes	Nursing
Prosthesis	Enter any device patient has or is using	General	Yes	Entry by Rehab, Nursing
Protocol Appts	Scheduled tests or appointments that are not otherwise noted on the Orders Summary.	General	Yes	Entry by Prescribers, study coordinators and research nurses
Pt Maiden Name	Patients maiden name	General	No	Interfaced
Special Needs	Enter any special needs, disabilities etc	General	Yes	Entry by Nursing
VAD Line Hx (Also, entered in Clin Doc)	Suggested content to be entered into the description field as follows: Type of VAD (tunneled, percutaneous, implanted), Insertion date and location, Access/reaccess date, Type of access needle, Special dressing requirements, Sutured in place, Line complications (unable to draw back, pertinent imaging studies, interventions performed for clotted ports)	General	Yes	Entry by Nursing and VAD Service staff

Table 1: Comment Types

How to Add a Comment

1. In the **Patient Info** chart section **Data Entry** list, select **Comment**. The **Comment Details (Adding New)** dialog box opens.
2. Select a comment **Type** from the drop-down list.
3. Enter the comment.
4. Click **OK**. The new comment displays in the **Allergies/Comments Summary Views** list.



Screen12:6 Comment Details Dialog Box

How to Edit a Comment

1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Double-click a comment, or select a comment and click **Details**. The **Comment Details** dialog box opens.
3. Edit the comment.
4. Click **OK**.

How to Discontinue a Comment

1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Double-click a comment, or select a comment and click **Details**. The **Comment Details** dialog box opens.
3. Click **Discontinue**.
4. Click **OK**. The status of the comment changes to **Inactive**.

How to Delete a Comment

1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Double-click a comment, or select a comment and click **Details**. The **Comment Details** dialog box opens.
3. Click **Delete**. A confirmation message displays.
4. Click **OK**.

Maintain Height/Weight Information

Height and weight should be entered into the Vital Signs flowsheet. Once saved into this flowsheet, height and weight will be automatically copied into the **Height/Weight** data entry option in the **Patient Info** chart section. This height and weight will be used for drug calculations during order entry unless modified by the ordering Prescriber.

Body Surface Area Formula

The following formula is used to calculate body surface area:

- Standard BSA = $\text{Height}^{0.725} \times \text{Weight}^{0.425} \times 0.007184$

Height is measured in centimeters; weight in kilograms and the result (BSA) is in square meters in both formulas. The BSA is rounded to two decimal places.

Maintain Significant Event Information

You can capture major events called Significant Events that can be viewed across visits and will not need to be re-entered. There are five data entry types available to you.

- Consents
- Immunizations
- Isolation Status
- Tracheostomy History
- Transfusion History

You can add significant events by clicking the **Significant Event** data entry option in the **Patient Info** chart section. Some of the types will have a scope of **General** (such as Immunization History or Surgical Procedures), and some will have a scope of **This Chart** (such as Critical Incidents).
Note: *You can also view, add, and edit Significant Events from the Clinical Summary Tab*.

Significant Event Type Table

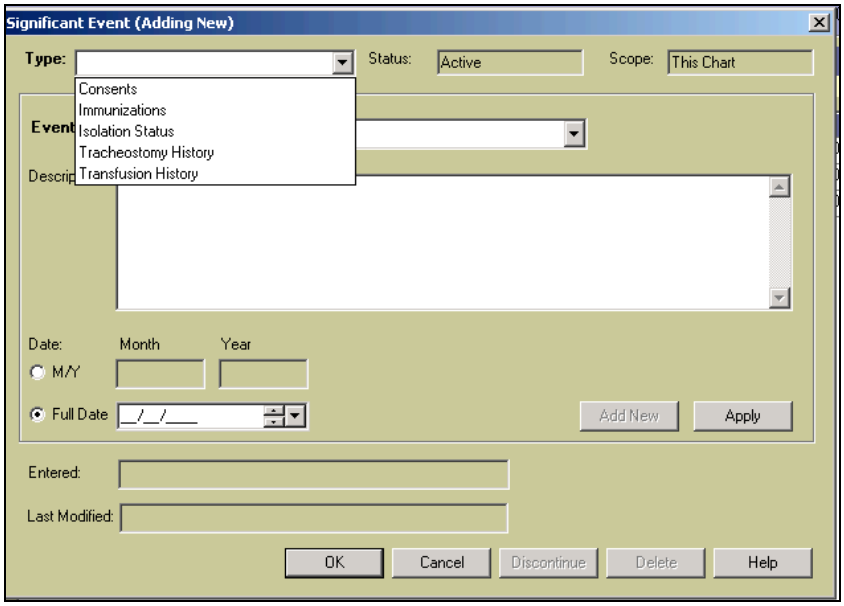
Significant Event Type	Event/Description	Scope	Entered By
Consents	Used for entering type of consent and dates signed. Pull down menu options (events): • Blood administration consent • Notification of information practices • Protocol consent Additional information to be entered in the Description Field	General	Nursing
Immunizations	Used to enter patient's immunization status. Pull down menu options (events): • DPT • H Influenza • Hepatitis A • Hepatitis B • Influenza • MMR • Oral Polio • Other • Pneumococcal • Varicella Additional information to be entered in the Description Field	General	Nursing
Isolation Status (Will also be placed as an order by Epidemiology)	Used to enter patient's isolation status. Pull down menu options (events): • AFB Isolation • CNS Precautions • Contact Isolation • None • Respiratory Isolation • Special Respiratory Isolation • Strict Isolation Additional information to be entered in the Description Field	General	Epidemiology and Nursing (if needed)
Tracheostomy History	Free Text	General	Health care provider
Transfusion History	Used to enter patients transfusion history information.	General	DTM and Nursing

Significant Event Type	Event/Description	Scope	Entered By
(This also occurs in more detail in Clin Doc)	Pull down menu options (events): ○ Allergic Reaction ○ Anaphylactic Reaction ○ Febrile Nonhemolytic Reaction ○ HLA Matched Platelet Restrictions ○ Patient Antibodies ○ Pre-Medication ○ Prior Transfusion ○ Refusal of Blood Products ○ Septic Reaction ○ Washed Blood Restrictions Additional information to be entered in the Description Field		

Table 2: Significant Event Types

How to Add a Significant Event

1. In the **Patient Info** chart section **Data Entry** list, select **Significant Event**.
2. The **Significant Event Details** dialog box opens.
3. Select a significant event **Type** from the drop-down list.
4. Choose an **Event** from the drop-down list, or enter text about an event.
5. Enter a **Description** of the event, if desired.
6. Enter the **Date** the significant event occurred. You can enter a partial or full date.
7. Click **OK**.



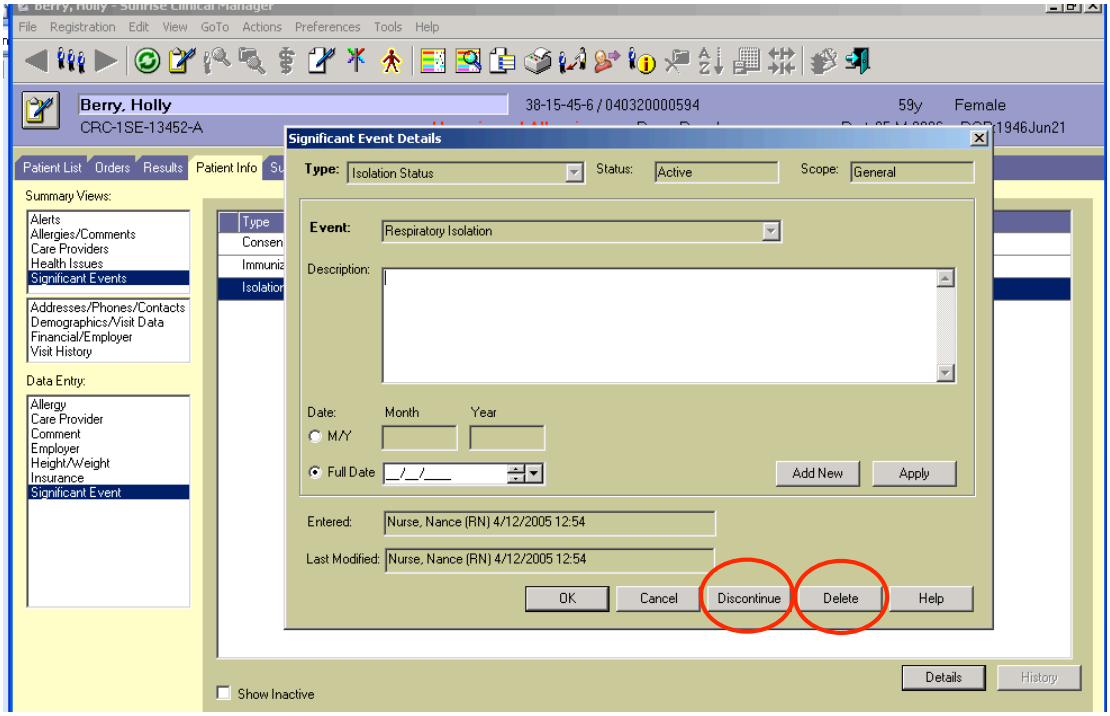
Screen12:7 Significant Events Dialog Box

How to Edit a Significant Event

1. In the **Patient Info** chart section **Summary Views** list, select **Significant Events**.
2. Double-click a significant event, or select a significant event and click **Details**.
3. The **Significant Event Details** dialog box opens.
4. Make the desired edits. Note that you cannot edit the **Type** or **Event**.
5. Click **OK**.

How to Discontinue a Significant Event

1. In the **Patient Info** chart section **Summary Views** list, select **Significant Events**.
2. Double-click a significant event, or select a significant event and click **Details**.
3. The **Significant Event Details** dialog box opens.
4. Click **Discontinue**.
5. Click **OK**. The status of the significant event changes to **Inactive**.



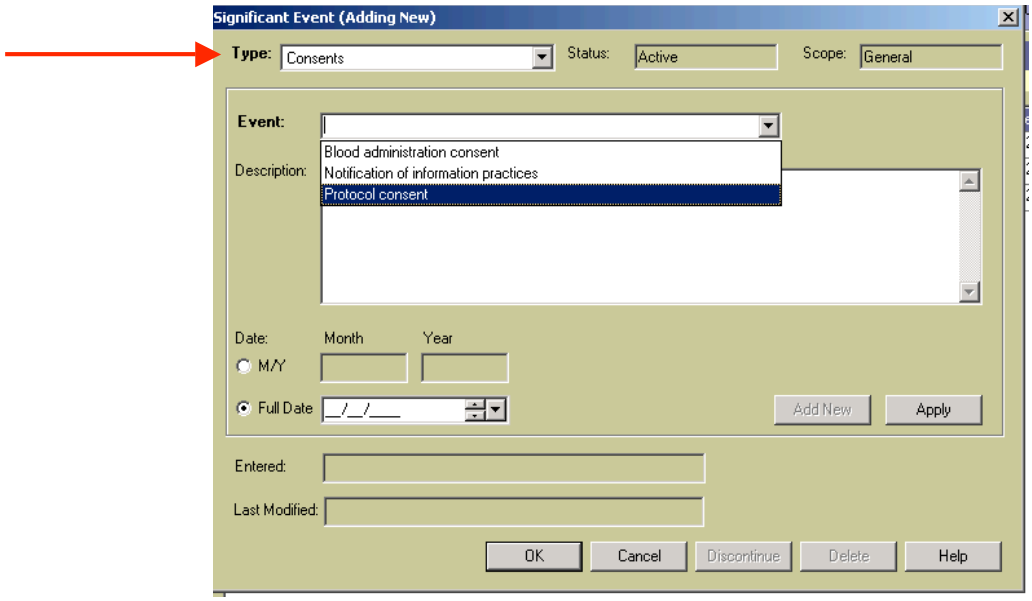
Screen 12.8 Discontinue or Delete a Significant Event

How to Delete a Significant Event

1. In the **Patient Info** chart section **Summary Views** list, select **Significant Events**.
2. Double-click a significant event, or select a significant event and click **Details**.
3. The **Significant Event Details** dialog box opens.
4. Click **Delete**. A confirmation message displays.
5. Click **OK**.

Enter Consent Information as a Significant Event

Consent information is entered in the Patient Info Significant Event section.

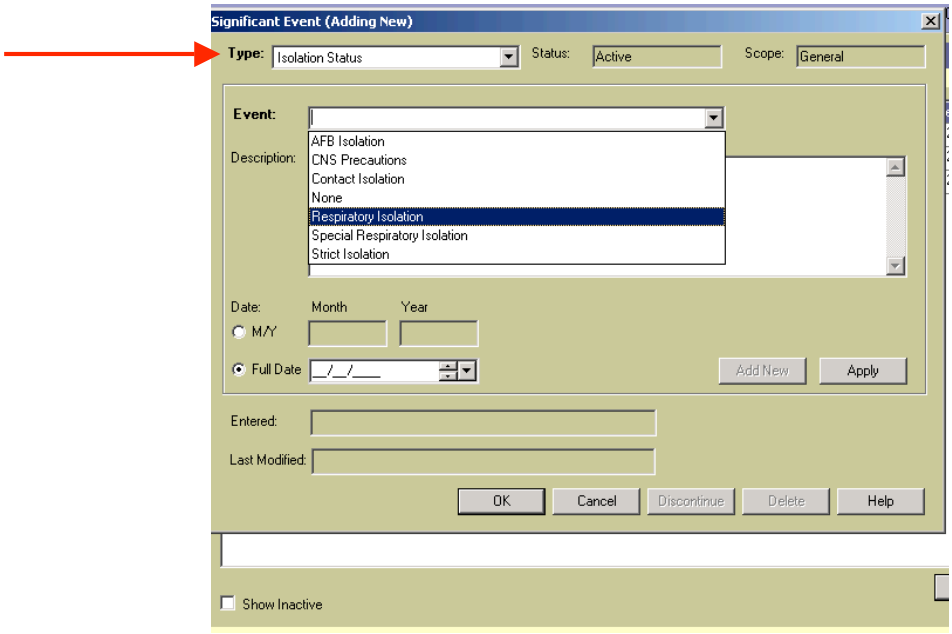


Screen 12.9: Enter consent information

1. In the **Patient Info** chart section **Data Entry** list, select **Significant Event**.
2. The **Significant Event Details** dialog box opens.
3. Select the **Type *Consents*** from the drop-down list.
4. Choose a consent **Type** from the drop-down list, or enter text about an event. Options include:
    a. Blood administration consent
    b. Notification of information practices and
    c. Protocol consent.
5. Enter additional information about the consent into the **Description** field, if desired.
6. Enter the **Date** the consent was signed. You can enter a partial or full date.
7. Click **OK**.

Enter Isolation Status as a Significant Event

The Epidemiology Service staff member enters the isolation status under Significant Events after the isolation order is reviewed for appropriateness.

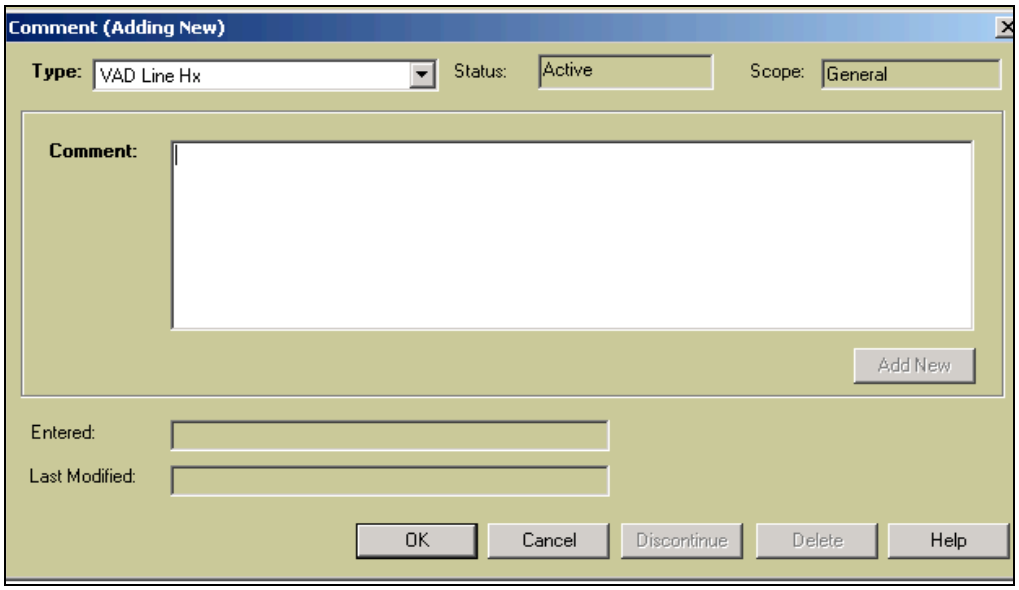


Screen 12.10: Isolation documentation

1. In the **Patient Info** chart section **Data Entry** list, select **Significant Event**.
2. The **Significant Event Details** dialog box opens.
3. Select the **Type** ***Isolation Status*** from the drop-down list.
4. Choose an isolation **Type** from the drop-down list, or enter text about an event.
5. Enter additional information about the consent into the **Description** field, if desired.
6. Enter the **Date** the isolation was ordered. You can enter a partial or full date.
7. Click **OK**.

Enter VAD Line History as a Comment

VAD line history information is entered in the Patient Info Comments section.



Screen 12.11: Enter VAD Line History

1. In the **Patient Info** chart section **Data Entry** list, select **Comment**. The **Comment Details (Adding New)** dialog box opens.
2. Select the comment **Type *VAD Line Hx*** from the drop-down list.
3. Enter any significant information about into the **Comment** field.
4. Click **OK**.